



# Jackson Hospital Volunteer Application

334-293-8805 | www.jackson.org

Send completed applications by:

**email:** Pryer.Hines@jackson.org

**fax:** 334-293-8971

**mail:** Jackson Hospital

Attn: Marketing

Jackson Hospital

1725 Pine St, Montgomery, AL 36106

**Application Date** \_\_\_\_\_

**Personal Information:**  Mr.  Mrs.  Ms.  Rev.  Dr. Sex:  Male  Female

Last name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of birth: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Shirt size: \_\_\_\_\_ Email: \_\_\_\_\_

**Current Work Experience:**  Volunteer  Paid

Business or Organization: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Work performed or title: \_\_\_\_\_

**Other Experience:**  Volunteer  Paid

Business or Organization: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Work performed or title: \_\_\_\_\_

## Educational Background:

High School  College  Graduate School  Vocational  Other: \_\_\_\_\_

Major(s): \_\_\_\_\_

Name of School: \_\_\_\_\_ Graduation Year: \_\_\_\_\_

Are you CPR certified? \_\_\_\_\_

Have you ever had a positive TB skin test? \_\_\_\_\_

Have you ever been convicted of a crime? If so, please explain. \_\_\_\_\_

\_\_\_\_\_

**Drivers License:**

Do you have a valid Alabama Driver's License?  Yes  No Driver's License #: \_\_\_\_\_

Do you have transportation?  Yes  No

**Emergency Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

**Motivation:**

What or who encouraged you to become a volunteer: \_\_\_\_\_

Have you volunteered before:  Yes  No

If yes, for what organization(s): \_\_\_\_\_

**Availability for Work:** (please check all that apply)

Days of the week I am available to volunteer are:

Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday

Times available:  AM  PM

**References:** (at least one person not related to you) References will be checked.

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

**Ethnicity:** (Optional)

African American  American Indian/Native Alaskan  Asian/Pacific Islander

Caucasian  Hispanic  Other \_\_\_\_\_

I understand and agree to the fact that this agreement is for participation with Jackson Hospital as a volunteer and that I will not be compensated for this work now or in the future. I have given the above information voluntarily, and I certify that all statements are true and correct. I understand that it will be used and disclosed for Jackson Hospital purposes or to any party with legal and proper inter-est, and I release Jackson Hospital from any liability whatsoever for supplying such information. I agree to abide by the Volunteer Personnel Policies and Procedures of Jackson Hospital.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature (if under 18): \_\_\_\_\_ Date: \_\_\_\_\_

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**For Office Use Only**

Application Received: \_\_\_\_\_ Volunteer Start Date: \_\_\_\_\_

Volunteer Orientation: \_\_\_\_\_ Volunteer Assignment: \_\_\_\_\_